

# New Level Of Care (LOC) Screening Tool for PASRR Users

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# What Is LOC?

- Level Of Care (LOC) screening:
  - Used by Nevada Medicaid to determine if the individual meets Nursing Facility (NF) LOC criteria
  - The LOC assessment also assesses individuals for the possibility of qualifying for other less restrictive services, which may be community-based, or to qualify for waiver services
  - NF must request a new LOC determination when it appears the resident no longer meets an NF standard LOC

# What is the LOC Screening Tool?

- LOC and PASRR in one online system
- Simplifies access for providers
- Notifications available online in the LOC/PASRR system
- NF must request a new LOC determination when it appears the resident no longer meets an NF standard LOC

# The Screening Tool Process

- Provider submits an LOC request in the same manner as the PASRR (Pre-Admission Screening Resident Review)
- Data is processed by the business and workflow rules engine
- System will automatically determine the proper flow for the request and move the task into the appropriate queue for processing

# The Screening Tool Process

- Real-time or near real-time determination is rendered via auto adjudication process
- Each request will be executed by an automated task or human centric determination if required
- Tool generates appropriate determination letters

# Accessing the LOC Application

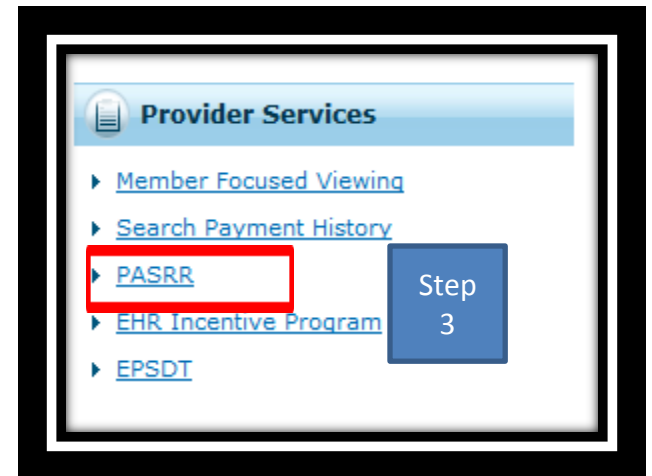
To access the LOC application:

- Go to [www.medicaid.nv.gov](http://www.medicaid.nv.gov)

Step 1: Click on the EVS tab, and then HPES Login

Step 2: Enter User ID

Step 3: Click on PASRR



# Logging on to the Application

- Log in to the Uniform Screening Tool
- Enter your User ID and Password
- Click Login

Launch PASER > Welcome > ? Log In

Welcome

**Login Into MUST:**

User ID:  ?

Password:  ?

[Cancel](#)

Note: After some period of inactivity, the system will log you out automatically and ask you to log in again.

**New User?:**

Not registered? [Sign up](#)

Login Help? [Help](#)

User Documentation? [Help](#)

**Uniform Screening Tool (MUST)**

**Notice to User:**

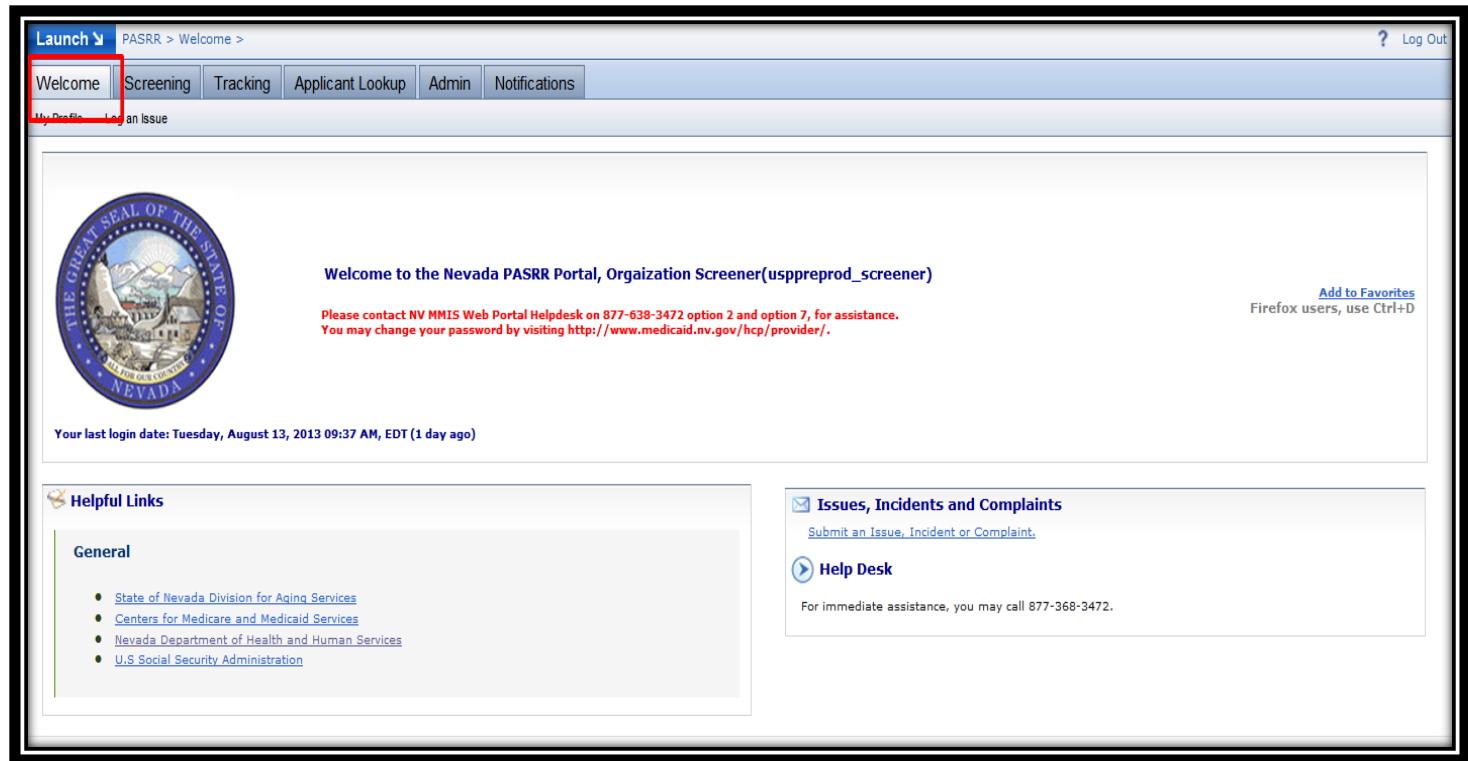
The Web Portal contains information which is intended only for the use of the individual or entity associated with the North Carolina Medicaid Uniform Screening Tool (MUST). Any unintended user is hereby notified that the information is privileged, trade secret and confidential, and any disclosure, reproduction or use of this information is prohibited.

The information collected in the MUST instrument is considered to be confidential personal health information. This data is considered sensitive and all necessary protections will be employed to keep the data secure and confidential. All screening organizations and respective employees are expected to uphold North Carolina Division Of Medical Assistance (DMA) HIPAA guidelines and their own Agency HIPAA policies. Any breach in confidentiality needs to be reported to your respective organization HIPAA official. Please goto [NC DHHS](#) for more details.

APP.19.156  
Last Updated: 2011/02/12/17/00  
Build: 131

# LOC Screening Module

- The Welcome Page will display





# Applicant Lookup

Once you have entered the system:

- Click on Applicant Lookup to determine if the recipient is already in the system
- Enter the search criteria
- When recipient is identified click on applicant's last name

The screenshot shows the PASRR Applicant Lookup interface. A blue arrow points to the 'Applicant Lookup' tab in the top navigation bar. Below the navigation bar, there is a section for 'Current Organization details and User roles' with a link to 'Click Here to expand/collapse'. The main section is titled 'Enter your search criteria:' and contains several input fields: 'Name (Last, First)\*', 'SSN\*\* (999999999):', 'Date of Birth (mm/dd/yyyy):', 'Screening ID (99999999):', 'Medicaid ID:', 'PASRR Number:', and 'NVP ID (999999):'. A blue arrow points to the 'Date of Birth' field. Below these fields are 'Search' and 'Clear' buttons. A note states: 'Your search criteria must contain a combination of 3 unique values or the Screening ID along with one other value. \* The first and last name count as one value. \*\* If Applicant/Patient doesn't have an SSN, check 'Undocumented Resident'.' Below this is a 'Select an Applicant' section with a table of search results. A blue arrow points to the 'Last Name' column in the table.

NVP ID	Last Name	First Name	Middle Name	Date Of Birth	Gender	SSN	Medicaid ID
155675	Lefty						

# Applicant Look-Up: Existing LOC

- After selecting the recipient's last name, if an LOC is already in place it will be indicated under screening history

The screenshot displays the 'Applicant Look-Up' interface. The top navigation bar includes 'Welcome', 'Screening', 'Tracking', 'Applicant Look-Up' (highlighted with a red box), 'Admin', 'Notifications', 'Reports', and 'Third Party'. Below the navigation bar, a link 'Click Here' is provided for expanding/collapsing organization details. The main section is divided into two parts. On the left, the 'Enter your search criteria' section contains a 'show search criteria' link and a form with fields for 'Name (Last, First)\*', 'SSN\*\* (999999999)', 'Date of Birth (mm/dd/yyyy)', 'Medicaid ID', 'PASRR Number', and 'NVP ID (999999)'. Several fields are highlighted with red boxes. A 'Search' button and a 'Clear' button are at the bottom of the form. On the right, the 'Screening History' section is highlighted with a red box and a blue arrow. It contains a table with columns: 'Screening ID', 'Status', 'Screening Type', 'Submission Date', 'Completed Date', 'Screener Organization', and 'Screener Name'. The table has one row with the following data: '124240', 'LOC Manual Review', 'Initial Placement', '08/08/2013', an empty 'Completed Date' field, and 'Screener, Organization'. The 'Screener Organization' field is highlighted with a red box.

Current Organization details and User roles: [Click Here](#) to expand/collapse

Enter your search criteria:

[show search criteria](#)

Name (Last, First)*	SSN** (999999999):	Date of Birth (mm/dd/yyyy):
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
Screening ID (99999999):	Medicaid ID:	PASRR Number:
<input type="text"/>	<input type="text"/>	<input type="text"/>

Search Clear

Your search criteria must contain a combination of 3 unique values or the Screening ID along with one other value.  
\* The first and last name count as one value.  
\*\* If Applicant/Patient doesn't have an SSN, check 'Undocumented Resident'.

Screening History

Screening ID	Status	Screening Type	Submission Date	Completed Date	Screener Organization	Screener Name
<a href="#">124240</a>	LOC Manual Review	Initial Placement	08/08/2013		<input type="text"/>	Screener, Organization

# Screening History

- After selecting the recipient's last name, if an LOC is already in place, you may select the Screening ID to view the history
- Click on the arrow to expand Latest Notifications to view the most current LOC

Screening History						
Screening ID	Status	Screening Type	Submission Date	Completed Date	Screener Organization	Screener Name
<a href="#">124243</a>	Completed	Initial Placement	08/08/2013	08/08/2013		

<b>Applicant Information:</b> <b>Applicant ID: 166678</b>				<b>Re-Submission:</b> <a href="#">Resubmit</a> <small>A resubmit will bring up a new screening form with current screening data prepopulated. Only Applicant Demographics are prepopulated if the current screening is submitted prior to 30 days.</small>				
First Name	First Name	Middle Name	Date of Birth					
Initial	Standard							
IN	Latest PASRR #	Start Date	Expiration Date					
xx-xx-6344								
Medicaid ID	Latest Level Of Care #							
	2013220502							
				<b>Workflow Status:</b> ( LOC Complete )				
				<b>Latest Notifications:</b>				

Latest Notifications:	
File	Created On
<a href="#">loc_ped1_124243.pdf</a>	2013-08-08 19:48:50.0

# Accessing the Screening Module

- Click on the Screening Tab

Launch PASRR > Screening > ? Log Out

Welcome **Screening** Tracking Notifications

Current Organization details and User roles: [Click Here](#) to expand/collapse

Screenings My Inbox Submit New Screen

Screening Filter

Screening List

[ [Show Archived Screen](#) ]

1 >> Last Results Per Page: 25 Displaying: 1-25 of 29

Screening ID	Applicant Name	NVP ID	Status	Submission Date	Completed Date	Screener Name
<a href="#">124272</a>	Retest, Lou	166694	Saved			Screener, Orgaization <a href="#">more...</a>
<a href="#">124271</a>	denial, retest	166693	Completed	08/10/2013	08/10/2013	Screener, Orgaization <a href="#">more...</a>
<a href="#">124270</a>	Retest, Peds	166692	LOC Manual Review	08/10/2013		Screener, Orgaization <a href="#">more...</a>
<a href="#">124268</a>	Retest, Ann	166691	Completed	08/10/2013	08/10/2013	Screener, Orgaization <a href="#">more...</a>
<a href="#">124250</a>	peds, Lane	166685	Saved			Screener, Orgaization <a href="#">more...</a>
<a href="#">124249</a>	Venty, Irene	166684	Manual Review - Require Addl Info	08/09/2013		Helpdesk, USP <a href="#">more...</a>
<a href="#">124248</a>	Vent, Retro	166683	LOC Manual Review	08/09/2013		Screener, Orgaization <a href="#">more...</a>



# Submit New Screen

- Click on Submit New Screen Tab
- New Submission Screen is available
- Verify your contact information
- Enter the applicant information

The screenshot shows a web application interface for submitting a new screen. At the top, there are three tabs: 'Screenings', 'My Inbox', and 'Submit New Screen'. A blue arrow points to the 'Submit New Screen' tab. The form is divided into three main steps, each highlighted with a red box:

- Step 1. Verify Your Contact Information:** This section contains fields for 'Screener Name', 'Organization', 'Organization Id', 'Address', 'Telephone', 'Fax', and 'Email'. The 'Email' field is pre-filled with 'matt.gudaitis@hp.com'.
- Step 2. Enter Applicant Information:** This section contains fields for 'Last Name', 'First Name', 'Middle Name', 'SSN (999999999)', 'NVP ID', 'Date of Birth (mm/dd/yyyy)', 'Is Medicaid Eligible?' (with 'Yes' and 'No' radio buttons), and 'Medicaid ID'.
- Step 3. Enter Screening Type:** This section contains a 'Screening Type' dropdown menu. A red box highlights the dropdown, and another red box shows the expanded list of options: 'Initial Placement', 'PASRR(PAS)', 'Resident Review(RR)', 'Initial Placement', 'Retro-Eligibility', 'Service Level Change', and 'Time Limitation'.

At the bottom of the form, there is a 'Continue' button and a note: 'Enter the Applicant information above and then select the type of form you wish to complete. This information will automatically populate on the form. If you need'.

# Error Alert for Existing LOC

Existing LOC:

After filling out the applicant information on page one of the screening tool, if an existing LOC is in place you will receive an alert that a Level of Care already exists for the patient and you may have to change your screening type selection to continue

## Validation Messages/Errors:

- A Level Of Care (LOC) already exists for this patient. You may need to change your selection to continue.

### Step 1. Verify Your Contact Information



**Screener Name:**

**Organization:**

**Organization Id:**

Screener, Organization

CA1041069393

**Address:**

**Telephone:**

**Fax:**

**Email:**

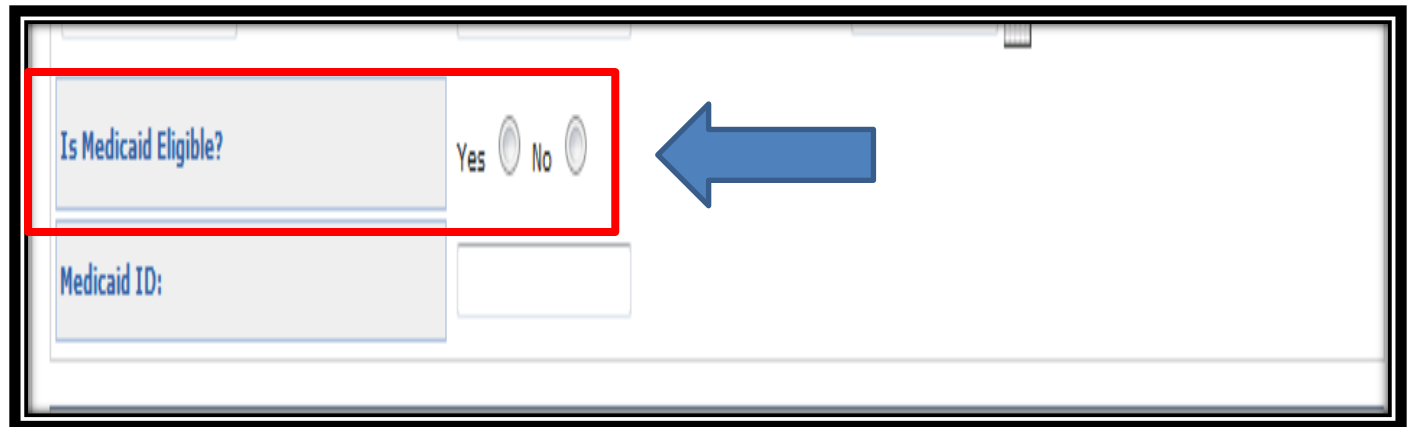
999-999-  
9999

999-999-  
9999

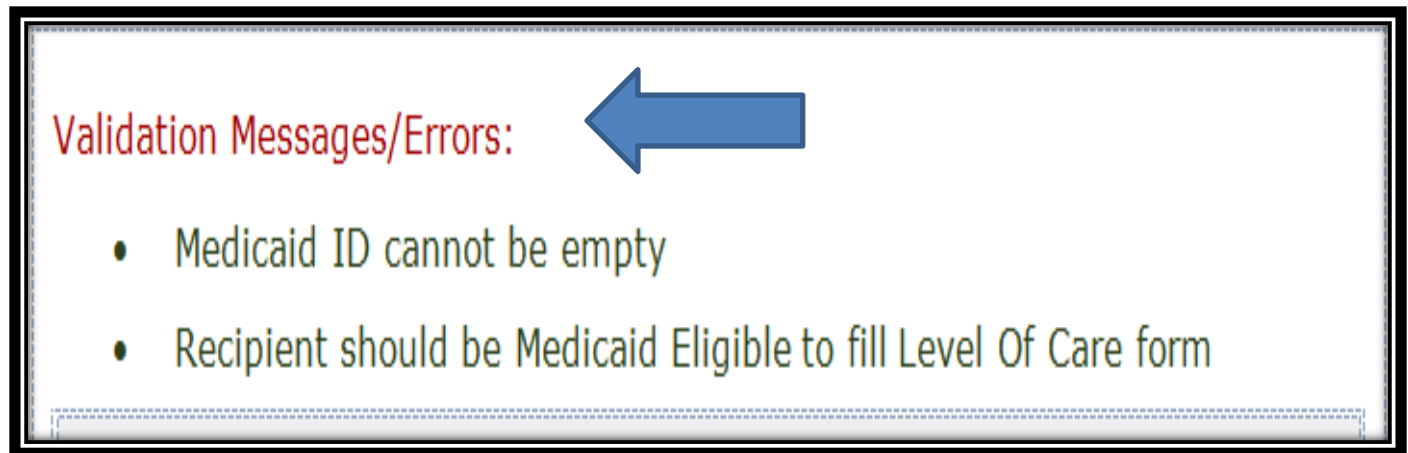


# Medicaid Eligibility

- Select if the applicant is Medicaid Eligible
- If you have selected YES, you will be able to proceed with the LOC screen
- If you have selected NO, the following message will appear and you will not be allowed to continue



The screenshot shows a form with two main sections. The top section is titled 'Is Medicaid Eligible?' and contains two radio buttons labeled 'Yes' and 'No'. This section is highlighted with a red rectangular box. A large blue arrow points from the right towards this box. Below this section is another field labeled 'Medicaid ID:' followed by an empty text input box.



The screenshot shows a message box titled 'Validation Messages/Errors:' in red text. Below the title, there are two bullet points in green text: 'Medicaid ID cannot be empty' and 'Recipient should be Medicaid Eligible to fill Level Of Care form'. A large blue arrow points from the right towards the message box.

# Screening Type

Select from the drop down box:

- Screening Type
- Click Continue

**Step 3. Enter Screening Type**

**Screening Type:** [Red box] ← [Blue arrow]

Select appropriate Screening Type based on the screening. The Screening Type can NOT be changed after you select.

**Initial Placement:** [Red box]

- PASRR(PAS)
- Resident Review(RR)
- Initial Placement
- Retro-Eligibility
- Service Level Change
- Time Limitation

**Service Level:** Standard [Red box]

**Continue** [Red box]

- Initial Placement: The recipient is being admitted into the nursing facility (NF) for the first time.
- Retro-Eligibility: The recipient was determined eligible for Medicaid benefits retroactively.
- Service Level Change: A recipient's service needs have changed. For example, the recipient was not ventilator dependent but now is or vice versa.
- Time Limitation: The previous LOC assessment was time limited and is close to expiration. For example, Pediatric specialty care I and II can only be approved for 180 days at a time.



# Service Level

Select from the drop down box:

- Level of Service
- Click Continue

**Step 3. Enter Screening Type**

Screening Type:  Initial Placement:

Select appropriate Screening Type based on the screening to be created. The Screening Type can NOT be changed after you start filling the form.

Service Level:  Standard

Continue

Standard  
Pediatric Specialty Care I  
Pediatric Specialty Care II  
Ventilator Dependent

- NF Standard encompasses a majority of recipients
- NF PED spec care I and II are limited to recipients birth to 21 years of age who require specialized, intensive, licensed skilled nursing care beyond the scope of services provided to the majority of NF recipients
- NF Ventilator Dependent is limited to recipients who are dependent on mechanical ventilation a minimum of 6 hours per day

# Screening Type and Requesting Facility - Page 1

- Screening Type and Requesting Facility or Provider Information will be auto-populated from the choices previously made

The screenshot displays the PASRR Screening form interface. The 'Screening' tab is selected in the top navigation bar. The 'Screening Type ?' section is highlighted with a red box and contains the following fields:

- Please Enter The Type of Screening:** A dropdown menu currently showing '-- Select --'.
- Date of Initiation:** A text field containing '2013-08-10T09:27:22.016'.
- Reason For Screening:** A list of radio button options: Initial Placement, Retro Eligibility, Service Level Change, and Time Limitation.
- LOC Service Level:** A list of radio button options: Standard, Pediatric Specialty Care I, Pediatric Specialty Care II, and Ventilator Dependent.

The 'Requesting Facility or Provider Information ?' section is also highlighted with a red box and contains the following fields:

- Screener:** A text field.
- Organization:** A text field.
- Professional Title:** A text field.
- Organization:** A text field containing 'Carson-Tahoe Hospital'.
- Screener Contact Name:** A text field.
- Screener Contact Org Name:** A text field.
- Screener Contact Org Id:** A text field.
- Screener Contact Org Address:** A text field.
- Screener Contact Org Phone:** A text field.
- Screener Contact Org Fax:** A text field.

# Entering Applicant Information

## - Page 1

- Applicant Name will be auto-populated
- Enter the Recipient's Permanent Mailing address and Phone Number
- Medicaid ID# is auto-populated
- Select from the drop down boxes the recipient's Gender and Medicaid Status
- Select from the drop down box the member's County of Residence
- Click Next

Applicant Information ?			
Last Name Retest		First Name Lou	Middle Name
Recipient's Permanent Mailing Address ?			
Street Address			
City	State Nevada	Zip Code	
Personal Details ?			
Social Security Number (999999999) <div></div>	Date of Birth (mm/dd/yyyy) 09/05/1962	Gender -- Select --	
Recipient's Home or Cell Phone Number 999-999-9999 <div></div>	Medicaid ID Number <div></div>	Medicaid Status -- Select --	
Medicaid County Of Residence -- Select --			
Screening ID: 124272		<div> <div>1</div> <div>2</div> <div>3</div> <div>4</div> <div>next &gt;&gt;</div> </div> <div>Save Validate Submit Delete</div>	

# Entering Diagnosis Information - Page 2

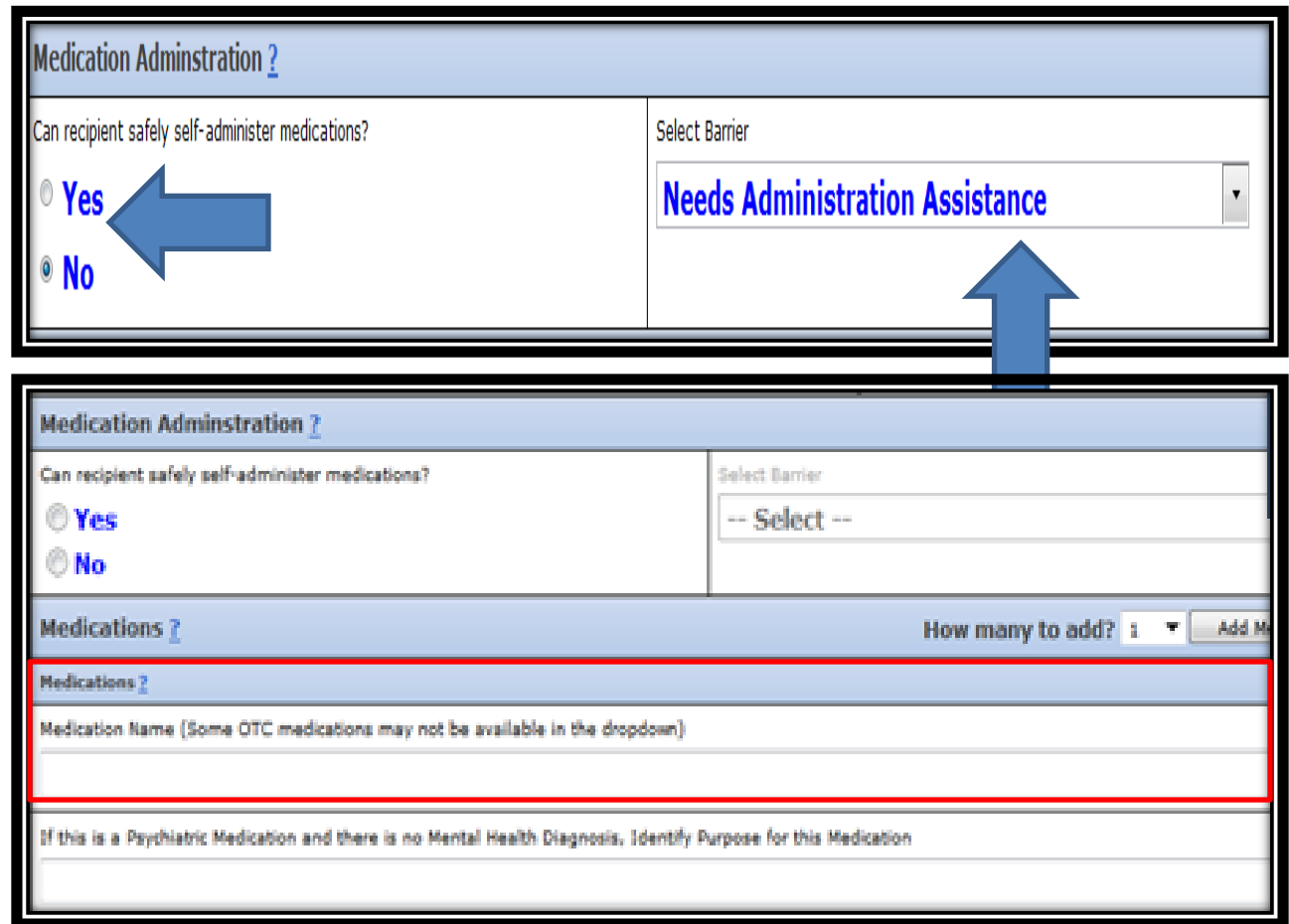
- Select from the drop down box the recipient's Diagnosis
- To enter additional diagnoses, indicate how many diagnoses you would like to add and click Add Diagnosis
- If diagnosis cannot be located in the drop down box, enter the diagnosis in the other field or enter the diagnosis code

<b>Diagnoses ?</b>		How many to add? 1 ▼	Add Diagnoses
<b>Diagnoses ?</b>			
Diagnosis (Current / Pertinent / Active)			
-- Select -- ▼			
If Other Diagnosis, Specify		ICD9 Code	
<input type="text"/>		<input type="text"/>	
<b>Medication Administration ?</b>			
Can recipient safely self-administer medications?		Select Barrier	
<input checked="" type="radio"/> Yes <input type="radio"/> No		-- Select -- ▼	
<b>Medications ?</b>		How many to add? 1 ▼	Add Medications
<b>Medications ?</b>			
Medication Name (Some OTC medications may not be available in the dropdown)			
<input type="text"/>			
If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication			
<input type="text"/>			



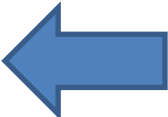
# Medication Administration

- Indicate whether the recipient can self-administer medication
- If No is selected, the provider will need to select the barrier from the drop down box on the right hand side
- If YES is selected, the Select Barrier option does not need to be completed
- One medication should be indicated in the Medication Name box. As the provider begins to type, a list of medications will be displayed for the provider to select



**Medication Administration ?**


Can recipient safely self-administer medications?

☐ Yes 

☒ No

Select Barrier

**Needs Administration Assistance**



---

**Medication Administration ?**

Can recipient safely self-administer medications?

☒ Yes

☐ No

Select Barrier

-- Select --

**Medications ?** How many to add? 1 Add M

**Medications ?**

Medication Name (Some OTC medications may not be available in the dropdown)

If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication

# Entering Additional Medications

- To enter additional medications, indicate how many medications you would like to add and click add medications
- The system will provide additional fields for entry

The screenshot shows a medical form with the following sections:

- Diagnoses ?**: Includes a dropdown for "Diagnosis (Current / Pertinent / Active)" with "-- Select --" as the current selection. Below this are two input fields: "If Other Diagnosis, Specify" and "ICD9 Code".
- Medication Administration ?**: Includes a section for "Can recipient safely self-administer medications?" with radio buttons for "Yes" and "No". To the right is a "Select Barrier" dropdown with "-- Select --" as the current selection.
- Medications ?**: This section is highlighted with a red box. It includes a dropdown for "Medication Name (Some OTC medications may not be available in the dropdown)" and a text input field for "If this is a Psychiatric Medication and there is no Mental Health Diagnosis, Identify Purpose for this Medication".

In the top right of the "Medications ?" section, there is a "How many to add?" dropdown set to "1" and an "Add Medications" button. A blue arrow points from the bottom of the form up to the "Add Medications" button.

# Entering Special Needs Information

## Special Needs

- Select all special needs that apply – you can select one or more needs

Special Needs			
<input checked="" type="checkbox"/> Central Line	<input checked="" type="checkbox"/> Feeding Tube (G,J, NG tube)		<input checked="" type="checkbox"/> Glucose Monitoring
<input checked="" type="checkbox"/> Insulin Coverage (Sliding scale with variable coverage)	<input checked="" type="checkbox"/> IV	<input checked="" type="checkbox"/> O2	<input checked="" type="checkbox"/> Ostomy
<input checked="" type="checkbox"/> Pediatric Specialty Care	<input checked="" type="checkbox"/> PICC		<input checked="" type="checkbox"/> Saline-Lock
<input checked="" type="checkbox"/> Secured (Alzheimer) Unit	<input checked="" type="checkbox"/> Specialty Bed	<input checked="" type="checkbox"/> Suctioning	<input checked="" type="checkbox"/> Trach
<input checked="" type="checkbox"/> Ventilator Dependent		<input checked="" type="checkbox"/> Wound Care	
<input type="checkbox"/> DME			<input type="checkbox"/> Other
Other Special Need <input type="text"/>			

# Entering Activities of Daily Living

## Activities of Daily Living

- For all activities select from the drop down box the level of care needed

## Activities of Daily Living include:

1. Bed mobility
2. Transferring
3. Dressing
4. Eating/Feeding
5. Hygiene
6. Bathing

Note: If the level of care is anything other than independent or activity did not occur, you will be required to select the level of support needed in the column to the right.

**This is a requirement for all activities of daily living on page 2**

<b>Bed Mobility ?</b>	
Bed Mobility Self-Performance	Bed Mobility Support Provided
Independent	-- Select --
Independent	
Supervision	
Limited Assistance	
Extensive Assistance	
Total Dependence	
Activity Did Not Occur	
<b>Dressing ?</b>	
Dressing Self-Performance	Dressing Support Provided
-- Select --	-- Select --
<b>Eating/Feeding ?</b>	
Eating/Feeding Self-Performance	Eating/Feeding Support Provided
-- Select --	-- Select --

<b>Bed Mobility ?</b>	
Bed Mobility Self-Performance	Bed Mobility Support Provided
Supervision	One Person Physical Assist
<b>Transferring ?</b>	
Transferring Self-Performance	Transferring Support Provided
Limited Assistance	One Person Physical Assist
<b>Dressing ?</b>	
Dressing Self-Performance	Dressing Support Provided
Limited Assistance	One Person Physical Assist
<b>Eating/Feeding ?</b>	
Eating/Feeding Self-Performance	Eating/Feeding Support Provided
Limited Assistance	Setup Help Only
<b>Bladder Function ?</b>	
Bladder Function	Bladder Function Support
Supervision	Incontinent



# Entering Bladder and Bowel Function Information

## Activities of Daily Living

- For all activities select from the drop down box the level of care needed

Note: If the level of care is anything other than independent or activity did not occur, you will be required to select the level of support needed in the column to the right

Bowel Function ?	
Bowel Function	Bowel Function Support
-- Select --	-- Select --
-- Select --	
Independent	
Supervision	Bathing Support Provided
Limited Assistance	-- Select --
Extensive Assistance	
Total Dependence	Personal Hygiene Support Provided
Activity Did Not Occur	-- Select --
-- Select --	

Bladder Function ?	
Bladder Function	Bladder Function Support
Supervision	Incontinent

# Entering Locomotion Information

## Activities of Daily Living

- For all activities select from the drop down box the level of care needed

Note: If the level of care is anything other than independent or activity did not occur, you will be required to check all that apply under locomotion support in the column to the right

Locomotion 1	
Locomotion	Locomotion Support
-- Select --	<input type="checkbox"/> Bed/chair
-- Select --	<input type="checkbox"/> Bed Only
Independent	<input type="checkbox"/> Braces
Supervision	<input type="checkbox"/> Cane
Limited Assistance	<input type="checkbox"/> Crutches
Extensive Assistance	<input type="checkbox"/> Heavy Duty Bed
Total Dependence	<input type="checkbox"/> Hoyer Lift
Activity Did Not Occur	

Locomotion 2	
Locomotion	Locomotion Support
Supervision	<input type="checkbox"/> Bed/chair
	<input type="checkbox"/> Bed Only
	<input type="checkbox"/> Braces
	<input type="checkbox"/> Cane
	<input type="checkbox"/> Crutches
	<input type="checkbox"/> Heavy Duty Bed
	<input type="checkbox"/> Hoyer Lift
	<input type="checkbox"/> Quad Cane
	<input type="checkbox"/> Walker
	<input type="checkbox"/> Wheelchair
	<input type="checkbox"/> Other

# Entering Recipient's Need for Supervision & IADLs

Recipient's need for Supervision:

- Select all that apply
- You are able to select one or more of the needs for supervision

Meal Preparation:

- Select level of Self-Performance from the drop down box

Home Making Services:

- Select the level of Self-Performance from the drop down box

Recipients Need for Supervision ?		
<input checked="" type="checkbox"/> Behavior Problem	<input checked="" type="checkbox"/> Resists Care	
<input checked="" type="checkbox"/> Socially Inappropriate	<input checked="" type="checkbox"/> Wandering	
<input checked="" type="checkbox"/> Physically Abusive	<input checked="" type="checkbox"/> Safety Risk	<input type="checkbox"/> Verbally Abusive

Meal Preparation ?	
Meal Preparation Self-Performance	
-- Select --	
-- Select --	
Independent	
Supervision	
Limited Assistance	
Extensive Assistance	
Total Dependence	
Activity Did Not Occur	

Home Making Services ?	
Ordinary/Light Housework - Self-Performance	
-- Select --	
-- Select --	
Independent	
Supervision	
Limited Assistance	
Extensive Assistance	
Total Dependence	
Activity Did Not Occur	

# Form Completion

After completion of Page 2:

- Click Next or 3, if you are requesting a pediatric LOC
- Or you may click 4 to complete the submission process

Home Making Services ?

Ordinary/Light Housework - Self-Performance

-- Select --

Screening ID: 124272

<< prev 1 2 3 4 next >>

Save Validate Submit Delete

Note: Page 3 should only be selected for recipients birth to 21 years of age who require specialized, intensive, licensed skilled nursing care beyond the scope of services provided to the majority of NF recipients

# Entering Pediatric Specialty Care Information - Page 3 of form

This is Form FA-22 and is only required for a Pediatric Level of Care.

## Nursing Services Information:

- Select Yes or No if the recipient requires 24-hour nursing care
- If you select Yes, then you will be required to select one or more of the required nursing services
- If you select No, you will not have the capability to select any nursing services

## Treatment Procedures

- Select all treatment/procedures that apply to the recipient. You do have the capability to select one or more.

Note: If IV Therapy is selected, you must select one of the IV Therapies to the right side.

Nursing Services Information ?	
The recipient's condition requires 24-hour access to care from a registered nurse and there is documentation to support that the recipient has at least one of the following:	
<input checked="" type="radio"/> <b>Yes</b> <input type="radio"/> <b>No</b>	
<input type="checkbox"/> A tracheostomy requiring mechanical ventilation a minimum of 6 hours per day or the recipient is on a ventilator weaning program (time limited)	
<input type="checkbox"/> A tracheostomy requiring suctioning, mist or oxygen and at least one treatment procedure listed in the next section	
<input type="checkbox"/> Dependence on Total Parenteral Nutrition (TPN) or other intravenous (IV) nutritional support and at least one treatment procedure listed in the next section	
<input type="checkbox"/> Administration of at least two treatment procedures listed in the next section	
<input type="checkbox"/> Central or peripherally inserted central catheter (PICC) line management	
<input type="checkbox"/> Complex wound care (including stage III or IV decubitous wound or recent surgical or other recent wound) requiring extensive dressing or packing (time limited)	
<input type="checkbox"/> Daily respiratory care (60 minutes or more per day or continuous oxygen and saturation monitoring or percussion therapy)	
<input checked="" type="checkbox"/> Intermittent suctioning at least every eight hours and mist or oxygen as needed	
<input checked="" type="checkbox"/> <b>IV Therapy?</b> Select IV Therapy: <input type="radio"/> Administration of continuous therapeutic agents <input type="radio"/> Hydration <input checked="" type="radio"/> Intermittent IV drug administration of more than one agent	
<input type="checkbox"/> Assist required (quadriplegia or hoover lift)	
<input type="checkbox"/> Peritoneal dialysis treatments requiring at least 4 exchanges every 24 hours	
<input type="checkbox"/> Seizure Precautions?	
<input type="checkbox"/> Tube utilization (nasogastric or gastrostomy); foley, intermittent catheterization, PEG, rectal tube	





# Entering Applicant Behavior Issues, Discharge Potential and Justification

This is Form FA-22 and is only required for a Pediatric Level of Care.

Moderate Behavior Issues and Other special treatments:

- Select one or both of these needs
- If you select either one of these as being a member need, you will be required to enter a description of what the specific needs are in the column to the right

Discharge Potential

- Enter details of the member's potential for discharge

Justification

- Enter information to support the medical necessity of Pediatric specialty care
- If you have selected Pediatric Specialty Care I or II, you are required to attach documentation; indicate if you are faxing it.

<input type="checkbox"/> <b>Moderate behavior issues (including self abuse)</b> <b>Describe the problem behavior, frequency and severity:</b>	Describe the problem behavior, frequency and severity: <input type="text"/>
<input type="checkbox"/> <b>Other special treatment(s) not listed above -</b> <b>Describe in detail:</b>	Describe other Special Treatments in detail: <input type="text"/>
<b>Discharge Potential ?</b>	
Describe the recipient's potential for discharge from the pediatric unit to a lower level of care or home: <input type="text"/>	
<b>Discharge potential from the pediatric unit to lower level of care is possible</b>	
<b>Justification ?</b>	
Enter additional comments to support medical necessity of Pediatric Specialty Care Services (attach supporting documentation): <input type="text"/>	
<b>additional comments to support medical necessity of Pediatric specialty care services can be entered here</b>	

# Completion of Pediatric Specialty Care Page

After completing all information on Page 3:

- Click Next or the number 4

Discharge Potential ?

Describe the recipient's potential for discharge from the pediatric unit to a lower level of care or home:

Screening ID: 124272

[<< prev](#) [1](#) [2](#) **3** [4](#) [next >>](#)

Save Validate Submit Delete

# Submission Page

You are now ready to submit your request:

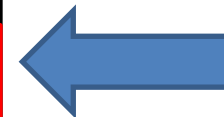
- Click Submit

☐ By checking this box I certify that I have completed the above screening of the applicant to the best of my knowledge.

I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation

Screening ID: 124272      << prev 1 2 3 **4**

Save Validate Submit Delete



# Error: Incomplete Information

If you have not completed all areas of the tool based on your selection of the screening type and service level:

- You will receive alerts directing you to the area of the tool that has not been completed
- To complete these alerts, click on the alert in the Section column and you will automatically be taken to that section of the tool to be completed
- Continue to click on each alert until all sections have been completed
- Once all alerts have been addressed you now are ready for submission
- Click on Submit

I understand falsification as: an individual who certifies a material and false statement in this screening will be subject to investigation for Medicaid fraud and will be referred to the appropriate state agency for investigation

Screening ID: 124272      << prev 1 2 3 4

Save Validate Submit Delete

Screenings My Inbox PASRR Level 2 Screens Submit New Screen

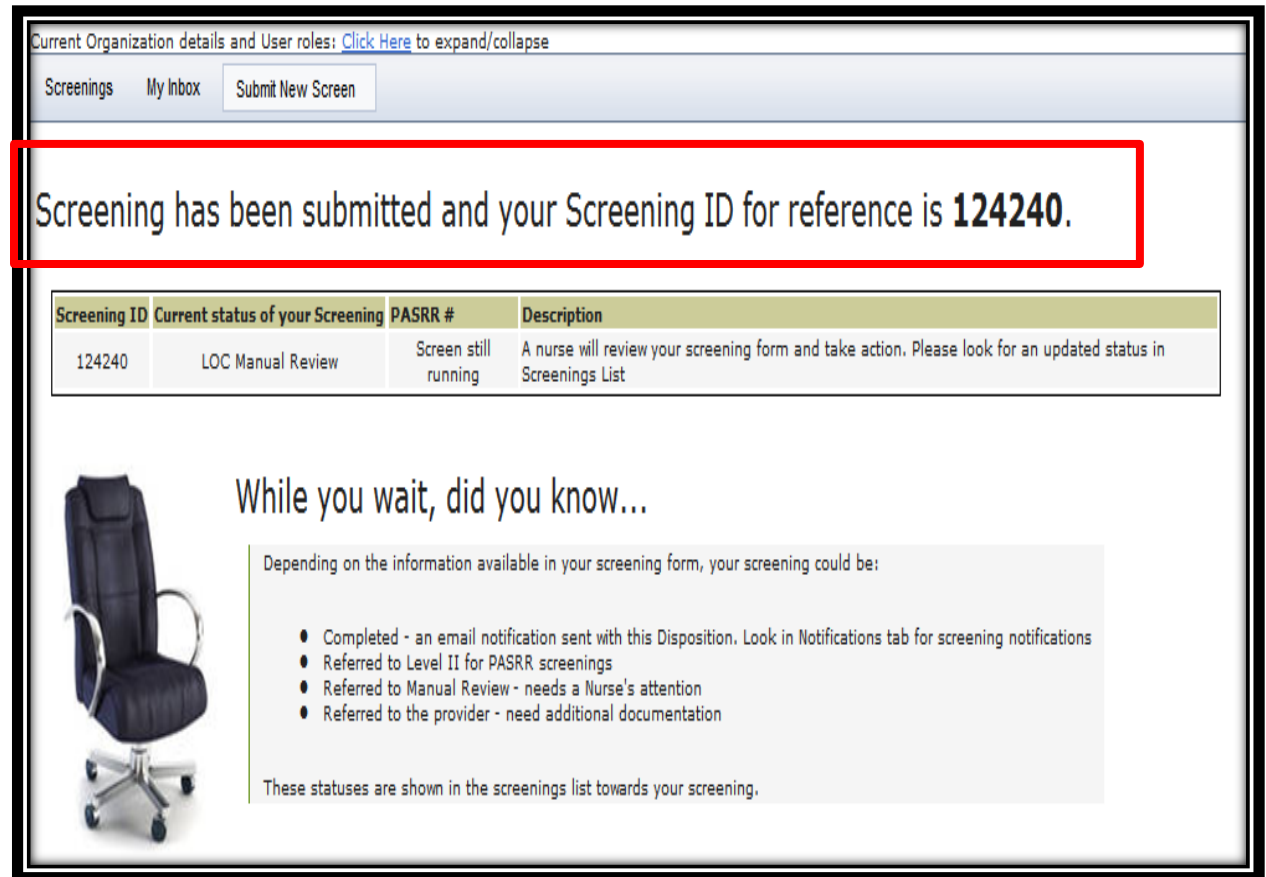
Fix the following errors and click Submit to submit your form:

Page Number	Error	Section
1	Street Address is required.	Recipient's Permanent Mailing Address
1	City is required.	Recipient's Permanent Mailing Address
1	Zip Code is required.	Recipient's Permanent Mailing Address
1	Gender is required.	Personal Details
1	Medicaid Status is required.	Personal Details
1	Medicaid County Of Residence is required.	Personal Details
2	Can recipient safely self-administer medications? is required.	Medication Administration
2	For checked items above, list the frequency/duration of treatment, the stage/grade/size/location of wounds and/or any other specific treatments: is required.	Special Needs
2	Transferring Self-Performance is required.	Transferring



# Request Submission

- Once your submission has been made you will receive the following screen as to the status of your request
- If the request goes to manual review, the LOC will be reviewed by a nurse and will either be completed and or returned for additional information
- If the recipient is not Medicaid eligible, you will receive a cancellation notice
- If the LOC is approved, you can go to the notifications tab to retrieve the letter



The screenshot displays a web application interface. At the top, a navigation bar includes links for 'Screenings', 'My Inbox', and 'Submit New Screen'. Below this, a red-bordered box contains the message: 'Screening has been submitted and your Screening ID for reference is **124240**.' Underneath the message is a table with the following data:

Screening ID	Current status of your Screening	PASRR #	Description
124240	LOC Manual Review	Screen still running	A nurse will review your screening form and take action. Please look for an updated status in Screenings List

Below the table, there is a section titled 'While you wait, did you know...' featuring an image of an office chair on the left. To the right of the chair, text states: 'Depending on the information available in your screening form, your screening could be:' followed by a bulleted list:

- Completed - an email notification sent with this Disposition. Look in Notifications tab for screening notifications
- Referred to Level II for PASRR screenings
- Referred to Manual Review - needs a Nurse's attention
- Referred to the provider - need additional documentation

At the bottom of this section, it says: 'These statuses are shown in the screenings list towards your screening.'

# Notification Tab

- From the notification list you can select the PDF File associated with the Screening ID

Current Organization details and User roles: [Click Here](#) to expand/collapse

Notifications List

Notification Filter

Notification List

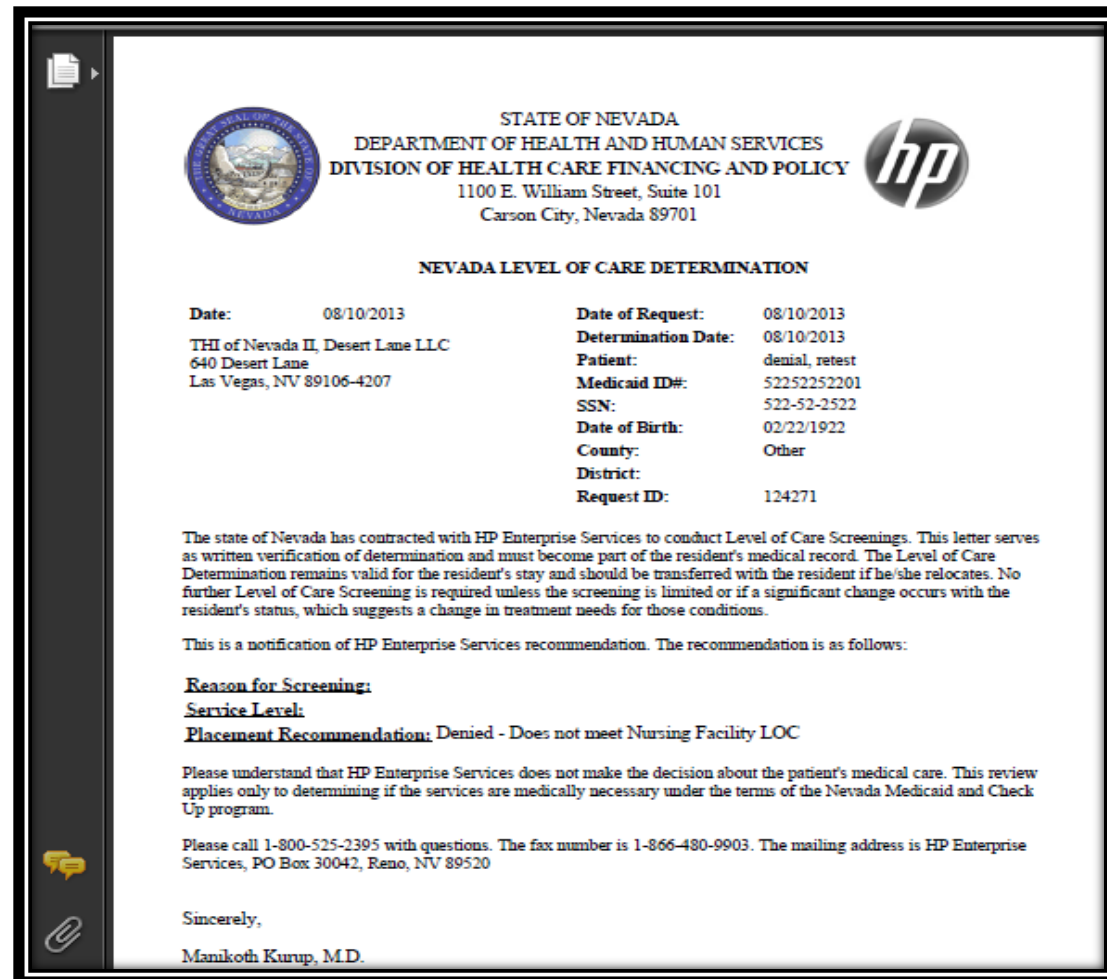
[ [Show Archived Notifications](#) ]

1 Results Per Page: 25 Displaying: 1-25 of 25

Log ID	Screening ID	Applicant Name	Notification Name	PDF File	Date Created	Date Sent	Receiver	Method	Address	Screen
<a href="#">19773</a>	<a href="#">124270</a>	Retest, Peds	LOC Pediatric Specialty Care	<a href="#">loc_ped1_124270.pdf</a>	08/15/2013	08/15/2013	Scree	Email	Scree	Scree

# Letter Generation

Once a determination has been made, a letter will be generated indicating the status and level of care



The screenshot shows a web-based form for generating a letter. The form is titled 'NEVADA LEVEL OF CARE DETERMINATION' and is part of the 'STATE OF NEVADA DEPARTMENT OF HEALTH AND HUMAN SERVICES DIVISION OF HEALTH CARE FINANCING AND POLICY'. The form includes fields for patient information, request details, and a section for the reason for screening. The patient information includes the name 'THI of Nevada II, Desert Lane LLC', address '640 Desert Lane Las Vegas, NV 89106-4207', and date '08/10/2013'. The request details include 'Date of Request: 08/10/2013', 'Determination Date: 08/10/2013', 'Patient: denial, retest', 'Medicaid ID#: 52252252201', 'SSN: 522-52-2522', 'Date of Birth: 02/22/1922', 'County: Other', 'District:', and 'Request ID: 124271'. The reason for screening is 'Denied - Does not meet Nursing Facility LOC'. The form also includes a section for the service level and placement recommendation, and a footer with contact information and a signature line.

**STATE OF NEVADA**  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 E. William Street, Suite 101  
Carson City, Nevada 89701

**NEVADA LEVEL OF CARE DETERMINATION**

**Date:** 08/10/2013  
**THI of Nevada II, Desert Lane LLC**  
640 Desert Lane  
Las Vegas, NV 89106-4207

**Date of Request:** 08/10/2013  
**Determination Date:** 08/10/2013  
**Patient:** denial, retest  
**Medicaid ID#:** 52252252201  
**SSN:** 522-52-2522  
**Date of Birth:** 02/22/1922  
**County:** Other  
**District:**  
**Request ID:** 124271

The state of Nevada has contracted with HP Enterprise Services to conduct Level of Care Screenings. This letter serves as written verification of determination and must become part of the resident's medical record. The Level of Care Determination remains valid for the resident's stay and should be transferred with the resident if he/she relocates. No further Level of Care Screening is required unless the screening is limited or if a significant change occurs with the resident's status, which suggests a change in treatment needs for those conditions.

This is a notification of HP Enterprise Services recommendation. The recommendation is as follows:

**Reason for Screening:**  
**Service Level:**  
**Placement Recommendation:** Denied - Does not meet Nursing Facility LOC

Please understand that HP Enterprise Services does not make the decision about the patient's medical care. This review applies only to determining if the services are medically necessary under the terms of the Nevada Medicaid and Check Up program.

Please call 1-800-525-2395 with questions. The fax number is 1-866-480-9903. The mailing address is HP Enterprise Services, PO Box 30042, Reno, NV 89520

Sincerely,  
Manikoth Kurup, M.D.



# LOC Screening Forms

To access LOC form FA-19, go to:  
www.medicaid.nv.gov

- Locate the FA-19 form and click to open
- Form FA-19 Instructions are also available

The screenshot shows the Nevada Department of Health and Human Services website. The 'Forms' link in the top navigation bar is highlighted with a red box. Below, a table lists various forms, with 'FA-19' and 'FA-19 Instructions' highlighted in orange and pointed to by a blue arrow. A second blue arrow points to the 'Level of Care Assessment Form for Nursing Facilities' form itself.

FA-17 Instructions	<a href="#">Adult Day Health Care Services Prior Authorization Request Instructions</a>
FA-18	<a href="#">Level 1 Identification Screening for PASRR</a>
FA-19	<a href="#">Level of Care Assessment for Nursing Facilities</a>
FA-19 Instructions	<a href="#">Level of Care Assessment for Nursing Facilities Instructions</a>
FA-20	<a href="#">PASRR and LOC Copy Request</a>
FA-21	<a href="#">PASRR and LOC Data Correction Form</a>
FA-22	<a href="#">Screening Request for Pediatric Specialty Care Services</a>
FA-24	<a href="#">Personal Care Services (PCS) Prior Authorization</a>   <a href="#">PCS Assessment Forms</a>
FA-24 Instructions	<a href="#">Personal Care Services (PCS) Prior Authorization Instructions</a>

HP Enterprise Services - Nevada Medicaid and Nevada Check Up  
**Level of Care Assessment Form for Nursing Facilities**

Fax this request to: (855) 709-6847      For questions regarding this form, call: (855) 525-2395

DATE OF REQUEST:  /  /

REASON FOR SCREENING: ☐ Initial Placement ☐ Retro-Eligibility ☐ Service Level Change ☐ Time Limitation

SERVICE LEVEL: ☐ Standard ☐ Pediatric Specialty Care I ☐ Pediatric Specialty Care II ☐ \*Ventilator Dependent  
*\*If ventilator dependent, you must attach medical records indicating the date the recipient went on/off the ventilator.*

**PROVIDER INFORMATION**

Provider Name:  NPI:

Person Completing This Form:  Professional Title:

Contact Phone:  Contact Fax:  Contact Pager:

**RECIPIENT INFORMATION**

Last Name:  First Name:  MI:  Recipient ID:

# LOC Screening Forms, continued

To access LOC form FA-22, go to:  
[www.medicaid.nv.gov](http://www.medicaid.nv.gov)

- Locate the FA-22 form and click to open

**Nevada Department of Health and Human Services**  
Division of Health Care Financing and Policy Provider Portal

Home Providers EVS Pharmacy Prior Authorization Quick Links Contact Us

Announcements/Newsletters Billing Information Electronic Claims/EDI E-Prescribing **Forms** NDC Provider Enrollment Provider Training

FA-17 Instructions	<a href="#">Adult Day Health Care Services Prior Authorization Request Instructions</a>
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FA-24	<a href="#">Personal Care Services (PCS) Prior Authorization</a>   <a href="#">PCS Assessment Forms</a>
FA-24 Instructions	<a href="#">Personal Care Services (PCS) Prior Authorization Instructions</a>

HP Enterprise Services - Nevada Medicaid and Nevada Check Up  
**Pediatric Specialty Care Services Screening Request**

**Fax this request to:** (855) 709-6847      **For questions regarding this form, call:** (800) 525-2395

**Purpose:** After a recipient is admitted to a Nursing Facility, use this form to request a Pediatric Specialty Care screening. The screening will determine whether the recipient qualifies for a Pediatric Specialty Care I or II reimbursement rate.

**Attachments:** Include with this form, 1) a copy of the completed Level of Care (LOC) screening form (FA-19) that was submitted for this recipient prior to Nursing Facility placement and 2) documentation to support or fully explain treatments the individual has received or is receiving.

**Notes:** A licensed health care professional must complete this form. Pediatric Specialty Care services may be authorized for up to six months per screening. Time-limited treatments such as ventilator weaning and complex wound care may be authorized for up to 90 days.

# Resources

**Website:**

[www.medicaid.nv.gov](http://www.medicaid.nv.gov)

Log into EVS (Select PASRR Link)

**PASRR/LOC:**

Phone: (800) 525-2395

Fax: (855) 709-6847

**State Website:**

[www.dhcfp.nv.gov](http://www.dhcfp.nv.gov)

**Requests for LOC Assistance**

Phone: (775) 335-8556

**Requests for Provider Training**

Email: [NevadaProviderTraining@hp.com](mailto:NevadaProviderTraining@hp.com)

Phone: (877) 638-3472



# Questions?



Thank you for your attention

We will be sending you a survey after this class by email. Please take the time to complete and pass on to others that may have attended with you but were not registered.

Enjoy the remainder of your day